

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-26	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2003	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)


6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.298	7. FEDERAL BUDGET IMPACT: a. FFY <u>2003</u> <u>\$10,081.92</u> b. FFY <u>2004</u> <u>\$40,630.15</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Item 1, Page 10 Attachment 4.19-A, item 1, Pages 10a & 10b Attachment 4.19-A, Item 1, Page 10c Attachment 4.19-A, Item 1, Page 10d Attachment 4.19-A, Item 1, Page 10e Attachment 4.19-A, Item 1, Pages 10f, & 10g Attachment 4.19-A, Item 1, Pages 10h, & 10i Attachment 4.19-A, Item 1, Page 10j(2) Attachment 4.19-A, Item 1, Pgs., 10k, 10k(1), 10k(2), 10k(3) ATTACHMENT 4.19A, Item 1, Pgs 10 K (4)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 03-19 Proposed) Same (TN 90-27) Same (TN 94-12) Same (TN 01-01) Same (TN 02-16) Same (TN 97-25) Same (TN 97-04) Same (TN 02-20) Same (TN 01-10) New PAGE

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to revise all provisions governing disproportionate share hospital payments in order to enhance federal revenue in the Medicaid Disproportionate Share Program.**

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

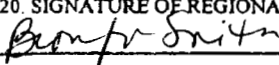
☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material**

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
13. TYPED NAME: David W. Hood	
14. TITLE: Secretary	
15. DATE SUBMITTED: September 23, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 29 2003	18. DATE APPROVED: APR 29 2004
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Charlene Brown	22. TITLE: Deputy Director, CMSO
23. REMARKS: Pen & Ink Change to Block #8 and 9	

STATE OF LOUISIANA
PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

CITATION 42CFR
447.253, OBRA 90
P.L. 101-508,
Sections 4702-4703

Medical and Remedial
Care and Services
Item 1 (Cont.)

C. Out-of-State Facilities-

Effective for dates of service on or after April 1, 2003, out-of-state facilities are reimbursed for inpatient hospital services at the lower of 40% of billed charges or the Medicaid per diem rate of the state wherein the services are provided for recipients age 21 and older and the lower of 60% of billed charges or the Medicaid per diem rate of the state wherein the services are provided for recipients under the age of 21. Hospitals designated as children's hospitals that are located in states that border Louisiana shall be reimbursed at the lower of the Medicaid per diem rate of the state wherein the services are provided or the Louisiana children's hospital Medicaid peer group rate. Neonatal intensive care unit services, pediatric intensive care unit services, and burn unit services provided in these children's hospitals shall be paid the Louisiana peer group rate for the qualifying level of service documented by the hospital. The hospital stay and the level of service shall be authorized by the Bureau.

For dates of service on or after March 8, 2000, out-of state facilities that provided at least five hundred (500) inpatient hospital days in State Fiscal Year 1999 to Louisiana Medicaid recipients and are located in border cities (cities located within a fifty (50) mile trade area of the Louisiana state border) will be reimbursed at the lesser of each facility's actual cost per day or the Medicaid per diem rate of the state wherein the services are provided. The actual cost per day is calculated from each hospital's 1998 filed Medicaid cost report by dividing total Medicaid inpatient cost by total Medicaid inpatient days, including nursery days. This is a one-time determination for the inpatient days and actual costs. This reimbursement methodology is applicable for all Louisiana Medicaid recipients who receive inpatient services in an out-of-state facility located in a border city, including those recipients up to the age of twenty-one.

D. Disproportionate Share Hospitals

Effective for inpatient hospital services provided on or after July 1, 2003, a payment adjustment for hospitals serving a disproportionate share of low income patients (DSH) shall be implemented in the following manner:

TN# 03-26
Supersedes
TN# 03-19

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CITATION
42 CFR
447.253
OBRA-90
P.L.
101-508
Sections
4702-4703

Medical and
Remedial
Care and
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Item 1 (Contd.)

1. Qualifying criteria for a Disproportionate Share Hospital:

- a. Hospital has at least two obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals who are Medicaid eligible. In the case of a hospital located in a rural area (i.e., an area outside of a metropolitan statistical area), the term obstetrician includes any physician who has staff privileges at the hospital to perform nonemergency obstetric procedures; or
- b. Hospital treats inpatients who are predominantly individuals under 18 years of age; or
- c. Hospital which did not offer nonemergency obstetric services to the general population as of December 22, 1987; and
- d. Hospital has a utilization rate in excess of one or more of the following specified minimum utilization rates:
 - (i) Medicaid Utilization Rate is a fraction (expressed as a percentage). The numerator is the hospital's number of Medicaid (Title XIX) inpatient days. The denominator is the total number of the hospital's inpatient days for a cost reporting period. Inpatient days include newborn and psychiatric days and exclude swing bed and skilled nursing days. Hospitals shall be deemed disproportionate share providers if their Medicaid utilization rates are in excess of the mean, plus one standard deviation of the Medicaid utilization rates for all hospitals in the state receiving payments; or
 - (ii) Hospitals shall be deemed disproportionate share providers if their low-income utilization rates are in excess of 25 percent. Low-Income Utilization Rate is the sum of:
 - (a) the fraction (expressed as a percentage), the numerator of which is the sum (for the period)

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CITATION Medical and
42 CFR Remedial
447.253 Care and
OBRA-90 Services
P.L. Item 1
101-508 (Contd.)
Sections
4702-4703

of the total Medicaid patient revenues plus the amount of the cash subsidies for patient services received directly from state and local governments. The denominator is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the cost reporting period from the financial statements; and

- (b) the fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charges for inpatient services which are attributable to charity (free) care in a period, less the portion of any cash subsidy as described in (ii) (a) above in the period which are reasonably attributable to inpatient hospital services; and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the period. For public providers furnishing inpatient services free of charge or at a nominal charge, this percentage shall not be less than zero (0). The above numerator shall not include contractual allowances and discounts (other than for indigent patients ineligible for Medicaid), i.e., reductions in charges given to other third party payors, such as HMOs, Medicare, or Blue Cross; nor charges attributable to Hill-Burton obligations.

A hospital providing "free care" must submit its criteria and procedures for identifying patients who qualify for free care to BHSF for approval. The policy for free care must be posted prominently and all patients must be advised of the availability of free care and procedures for applying. Hospitals not in compliance with free care criteria will be subject to recoupment of DSH and Medicaid payments; or

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-A
Item 1, Page 10 c

STATE OF LOUISIANA
PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

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TN# 03-26 Approval Date APR 29 2004 Effective Date JUL - 1 2003
Supersedes
TN# 94-12

STATE OF LOUISIANA
PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

- iii) Hospitals shall be deemed disproportionate share providers eligible for reimbursement for inpatient services if their inpatient uninsured utilization rates are in excess of 3 percent.

Inpatient Uninsured utilization rate is the fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charges for inpatient services furnished to uninsured persons for the period. The denominator is the total amount of the hospital's charges for inpatient services furnished to all persons for the period; or

- (iv) Hospitals shall be deemed disproportionate share providers eligible for reimbursement for outpatient services if their outpatient uninsured utilization rates are in excess of 3 percent.

Outpatient uninsured utilization rate is the fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charges for outpatient services furnished to uninsured persons for the period. The denominator is the total amount of the hospital's charges for outpatient services furnished to all persons for the period; or

- e. Effective November 3, 1997, be a small rural hospital as defined in I.D.3.b.; and
- f. In addition to the qualification criteria outlined in I.D.1.a.-e. above, effective July 1, 1994, the qualifying disproportionate share hospital must also have a Medicaid inpatient utilization rate of at least one percent (1%).

2. General Provisions for Disproportionate Share Payments

- a. Total cumulative disproportionate share payments under any and all DSH payment methodologies shall not exceed the federal disproportionate share state allotment for Louisiana for each federal fiscal year. The Department shall make necessary downward adjustments to hospitals' disproportionate share payments to remain within the federal disproportionate share allotment.

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Supersedes
TN# 01-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-A
Item 1, Page 10e

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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- b. Appropriate action including, but not limited to, deductions from DSH, Medicaid payments and cost report settlements shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.
- c. DSH payments to a hospital determined under any of the methodologies below shall not exceed the disproportionate share limits as defined in Section 1923(g)(1)(A) of the Social Security Act for the state fiscal year to which the payment is applicable. Any Medicaid profit will be used to offset the cost of treating the uninsured in determining the hospital specific DSH limits
- d. Qualification is based on the hospital's latest filed cost report as of March 31 of the current state fiscal year and related uncompensated cost data as required by the Department. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization. Qualification for small rural hospitals is based on the latest filed cost report. Hospitals must file cost reports in accordance with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports and related uncompensated cost data shall be assumed to be ineligible for disproportionate share payments.

Hospitals are notified by letter at least 60 days in advance of calculation of the DSH payment to submit documentation required to establish DSH qualification. Required documents are: 1) obstetrical qualification criteria form; 2) low income utilization revenue calculation; 3) Medicaid cost report; 4) uncompensated cost calculation. Only hospitals that timely return disproportionate share qualification documentation will be considered for disproportionate share payments.

After the final payment during the state fiscal year has been issued, no adjustment will be given on DSH payments, with the exception of public state-operated hospitals, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital.

TN# 03-26
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TN# 02-16

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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- e. Hospitals and/or units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle and thereafter.

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TN# 97-25

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Reimbursement Methodologies

High Medicaid hospitals can also qualify as Other Uninsured hospitals. All other qualifying hospitals shall be reimbursed in accordance with only one of the following reimbursement methodology categories.

a. High Uninsured Hospitals

- 1) High Uninsured Utilization Rate Hospital is a hospital that has an uninsured utilization rate in excess of the mean, plus one standard deviation of the uninsured utilization rates for all reporting hospitals.
- 2) DSH payments to individual high uninsured hospitals shall be calculated as follows:
 - (i) Inpatient High Uninsured – Payments shall be equal to 100 percent of the hospital's cost of furnishing inpatient hospital services to uninsured persons, supported by patient-specific data, net of any payments received from such patients. DSH payments calculated under this payment methodology shall be subject to the adjustment provision below in § 4); and/or
 - (ii) Outpatient High Uninsured – Payments shall be equal to 100 percent of the hospital's cost of furnishing outpatient hospital services to uninsured persons, supported by patient-specific data, net of any payments received from such patients. DSH payments calculated under this payment methodology shall be subject to the adjustment provision below in § 4).
- 3) It is mandatory that hospitals seek all third party payments including Medicare, Medicaid and other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Hospitals must maintain a log documenting the provision of uninsured care as directed by the Department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination. Patient specific data is required after July 1, 2003. Hospitals shall annually submit:

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